Sample

Medication Administration Packet

Page 1 - AUTHORIZATION TO GIVE MEDICATION
(TO BE COMPLETED BY PARENT)

_____ ____/____/____
Name of Facility/School Today's Date

_____ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours
_____

Dose _____ Route _____

Time to give medicine_____

Additional instructions _____

Date to start medicine _____/_____/_____ Stop date _____/_____/_____

Known side effects of medicine
_____
Plan of management of side effects
_____
Child allergies _____

PRESCRIBER'S INFORMATION

_____ _____
Prescribing Health Professional's Name Phone Number

PERMISSION TO GIVE MEDICINE
I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

_____
Parent or Guardian Name (Print)

_____
Parent or Guardian Signature

_____
Home Phone Number Work Phone Number Cell Phone Number

Adapted from Healthy Futures Medication Administration in Early Education and Child Care Settings

Sample

RECEIVING MEDICATION
To be Completed by Care Giver/Parent-Guardian

Name of child _____

Name of medicine _____

Date medicine was received _____/_____/_____

Safety Check

▫ 1. Child-resistant container.
▫ 2. Original prescription or manufacturer's label with the name and strength of the medicine.
▫ 3. Name of child on container is correct (first and last names).
▫ 4. Current date on prescription/expiration label covers period when medicine is to be given.
▫ 5. Start and Stop date are written on the Authorization form
▫ 6. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
▫ 7. Copy of Child Emergency Information is on file.
▫ 8. Instructions are clear for dose, route, and time to give medicine.
▫ 9. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
▫ 9. Child has had a previous trial dose. Y ▫ N ▫
▫ 10. When was child's last dose given?
▫ 11. Parent/Guardian has given instructions on administration
▫ 12. Is this a controlled substance? If yes, special storage and log may be needed.
□ 13. If this is an emergency medication has a 3 - Day Critical Medicaiton Authorization Form been completed?

_____
Caregiver/Teacher Name (Print)

_____
Caregiver/Teacher Signature

Adapted from Healthy Futures
Medication Administration in
Early Education and Child Care Settings

Sample

MEDICATION LOG Adapted from Healthy Futures Medication Administration in Early Education and Child Care Settings

Page 3

TO BE COMPLETED BY CAREGIVER/TEACHER

Name of Child _____ Weight of Child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medication					
Date	/ /	/ /	/ /	/ /	/ /
Actual Time Given	A.M._____ P.M. ____	A.M._____ P.M. ____	A.M._____ P.M. ____	A.M._____ P.M. ____	A.M._____ P.M. ____
Dosage/Amount					
Route					
Staff Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medication					
Date	/ /	/ /	/ /	/ /	/ /
Actual Time Given	A.M._____ P.M. ____	A.M._____ P.M. ____	A.M._____ P.M. ____	A.M._____ P.M. ____	A.M._____ P.M. ____
Dosage/Amount					
Route					
Staff Signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/ guardian notified and time/date	Caregiver/teacher signature

Returned to Parent/ Guardian	Date / /	Parent/Guardian Signature	Caregiver/Teacher Signature
Disposed Of Medicine	**Date / /**	**Caregiver/ Teacher Signature**	**Witness**